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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JENNY KUO-PAY CHIN 10870 Sunny Meadow Street San Diego, California 92126 Registered Nurse License No. 432974 Respondent.	Case No. 2009-202 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about October 31, 1988, the Board issued Registered Nurse License Number 432974 to Jenny Kuo-Pay Chin ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2009, unless renewed.

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JURISDICTION AND STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

5. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

6. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

Facts Supporting Causes For Discipline

7. At all times relevant herein, Respondent was employed as a registered nurse at the University of California, San Diego (U.C.S.D.) Medical Center, San Diego, California.

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8. In September of 1998, T.H. fell from a construction scaffold and suffered a fracture of the c-1 and c-2 vertebrae. After the injury, he remained ambulatory with the aid of a cane and wore a collar. For several weeks in November of 2002, he started experiencing general weakness. He was diagnosed with severe cord compression and generalized paresis in the upper and lower extremities with severe myelopathy including myelopathic gait and upper motor neuron signs in the upper and lower extremities.

9. On November 28, 2002, his second surgery, an anterior resection of the odontoid and then a stage posterior spinal fusion, was performed without complications at U.C.S.D. Medical Center.

10. The medical records reflect that T.H. was found out of bed, on the floor, and in a confused state on November 29, 2002, at 0115 and on November 30, 2002, at 0200. T.H. was examined and determined to have no injuries and was returned to bed on both occasions. At this time, T.H. was relocated to the eighth floor sitter room, which is designed to closely monitor patients at risk for falling. A nurse and nursing assistant are assigned to this room.

11. On December 1, 2002, commencing at 1900, Respondent came on duty and assumed care of T.H. as the nurse on duty with a nursing assistance in the eighth floor sitter room. Respondent documented a complete assessment of T.H. at approximately 2100 hours.

12. On December 2, 2002, T.H. was noted to be confused and agitated since about 0100 hours. Then, the following series of events occurred while T.H was under Respondent's care:

a. At approximately 0105, T.H. was found down on the floor. Respondent documented that T.H. was alert, awake, and no new deficit found. Respondent assessed T. H. and placed a call to the physician, but the only order was for a sitter, which T.H. already had. Respondent failed to take T. H.'s vital signs or delegate the vital signs assessment to the nursing assistant. T.H. was returned to his bed where he continued to turn, twist, and change positions in bed.

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b. At approximately 0115, Respondent documented that she assessed T.H. at the bedside. He knew the month, year, and UCSD as the hospital. However he was slow to answer and when asked what he was doing he stated he was "looking for a boy." Respondent did not give T.H. his Benadryl, because he was too sleepy. Respondent did not notify the doctor that she held the Benadryl.

c. At approximately 0230, T.H. was incontinent and was cleaned up. It was noted that he was quite restless, pulling at everything and trying to take his restraints off. No neurological assessment was done by nursing at that time.

d. At approximately 0251, it was discussed with T.H. that he must not get out of bed without assistance. T.H. stated that the first few nights he felt disoriented. He was noted to be alert, awake, no new deficit found.

e. At approximately 0300, T.H was noted to have labored heavy breathing and was groggy. T. H. had a respiratory rate of 24. Respondent gave him 2 liters of oxygen. Respondent failed to report the change in T. H.'s respiratory status to the physician, failed to perform a pulse oxymetry/oxygen saturation test prior to administering the oxygen to establish a baseline status on T. H., applied oxygen to T. H. without a physician's order, and failed to assess the effectiveness of the oxygen after administering it to T. H.

f. At approximately 0355, Respondent documented that T.H. was "quiet not moving, no pulse, started CPR. Code blue called." At approximately 0400, Respondent documented speaking to the doctor who advised her to call code blue. There was a delay in calling the code blue. The code blue record reflects that the call was documented as occurring at 0410, 15 minutes after the code blue was noted in Respondent's documentation.

13. T.H. was resuscitated, intubated, and transferred to the intensive care unit where his condition deteriorated.

14. On December 4, 2002, at approximately 1150 hours, T.H. was pronounced dead. An autopsy performed by the San Diego Coroner listed the cause of death as hypoxic/ischemic encephalopathy due to cardiopulmonary arrest associated with hemmorhagic necrosis of the cerebral spinal cord following cervical spine fusion due to remote odontoid

fracture with myelopathy. No clear reason for the hemmorhagic necrosis of the cerebral spinal or fatal cardiopulmonary arrest could be ascertained and the cause of death was ruled to be accidental.

15. Respondent was terminated from her employment as a result of this incident due to failure to follow procedures related to T.H.'s fall on December 2, 2002.

16. On or about June 23, 2005, the Board received a report of settlement, judgment, and arbitration award indicating that a settlement was reached with T.H.'s survivors, including a portion paid by Respondent. This investigation then ensued.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), in that Respondent committed acts constituting gross negligence as follows. On or about December 2, 2002, she did not provide a safe environment for T.H. who had a history of falling and did not keep T.H. safe from avoidable injury as described in paragraphs 7 to 12 above, which are incorporated by reference herein. Failure to keep T.H. from avoidable injury is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), in that Respondent committed acts constituting gross negligence as follows. On or about December 2, 2002, at approximately 0105 hours, T. H. was found down on the floor. Respondent assessed T. H. and placed a call to the physician, but failed to take T. H.'s vital signs or delegate the vital signs assessment to the nursing assistant, as described in paragraph 12a above, which is incorporated by reference herein. Failure to take the vital signs is an extreme departure from the standard of care for ongoing assessment of a patient.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), in that Respondent committed acts constituting gross negligence as follows. On or about December 2, 2002, at approximately 0115 hours, Respondent held T.H.'s Benadryl because he was too sleepy, but failed to notify the physician that she held the medication as described in paragraph 12b above, which is incorporated by reference herein. The failure to notify the doctor that she held T.H.'s Benadryl dose was an extreme departure from the standard of care.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), in that Respondent committed acts constituting gross negligence as follows. On or about December 2, 2002, at approximately 0300 hours, Respondent found that T. H. had a respiratory rate of 24 and gave him 2 liters of oxygen. Respondent failed to report the change in T. H.'s respiratory status to the physician, failed to perform a pulse oxymetry/oxygen saturation test prior to administering the oxygen to establish a baseline status on T. H., applied oxygen to T. H. without a physician's order, and failed to assess the effectiveness of the oxygen after administering it to T. H. as described in paragraph 12e above, which is incorporated by reference herein. The failure to take these actions was an extreme departure from the standard of care.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), in that Respondent committed acts constituting gross negligence as follows. On or about December 2, 2002, at approximately 0355, Respondent documented that T.H. was "quiet not moving, no pulse, started CPR. Code blue called." At approximately 0400, Respondent documented speaking to the doctor who advised her to call code blue. The code blue

record reflects that the call was documented as occurring at 0410, 15 minutes after the code blue was noted in Respondent's documentation as described in paragraph 12f above, which is incorporated by reference herein. The delay in calling a code blue or delegating the activation of the code team to another staff member was an extreme departure from the standard of care which placed T. H. at risk for a hypoxic event due to ineffective oxygenation during the resuscitation efforts.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

22. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about December 2, 2002, while employed as a registered nurse at the University of California, San Diego Medical Center, San Diego, California, Respondent committed acts constituting unprofessional conduct, as set forth in paragraphs 7 to 21 above, which are herein incorporated by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 432974, issued to Jenny Kuo-Pay Chin;

2. Ordering Jenny Kuo-Pay Chin to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/16/09.

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant